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Authorization for Release of Protected Health Information (PHI)

As required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, our office may not use or disclose your health information except as provided in our Notice of Privacy Practices without your signed authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of your Protected Health Information (PHI) as described herein. You may revoke this authorization at any time by providing SupraCare with a dated written revocation or, unless otherwise revoked, this authorization will expire ONE YEAR from the date signed. I understand that revoking this authorization does NOT apply to the extent that the person(s) authorized to use or disclose my health information have already acted in reliance on this authorization.

Patient Name_____ DOB_____

Address_____City_____ ST_____Zip_____

SS#_____ Phone#_____

I authorize SupraCare Family Health to: _____ RELEASE or _____OBTAIN

the following Protected Health Information (PHI):

_____ My complete health record _____ Lab reports only from: _____(list dates)

_____ My complete billing record _____ Radiology reports only from: _____(list dates)

_____ Other _____

Name of Provider/Facility:_____

Address/Location:_____

P: _____ F: _____

Please select the reason for this Authorization of Release of Protected Health Information (PHI):

_____ Personal _____ Legal _____ Continuation of care _____ Transfer of care

I understand that the information in my health record may contain information relating to sexually transmitted disease, acquired or mental health services, and treatment of alcohol and/or drug abuse. I understand that the release of Drug and Alcohol treatment records are protected by Federal Law (42 CFR Part 2) for Alcohol/Drug abuse. This law prohibits information disclosed from records protected by this law from being re-disclosed, without the specific written consent of the patient or as otherwise permitted by such law or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of such information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____Yes, I consent to the release of this information. _____No, I do NOT consent to the release of this information.

By signing below, I authorize the use and disclosure of my Protected Health Information as indicated above.

Patient/Guardian Print_____ Relationship to patient _____

Patient/Guardian Signature_____ Date_____